



Request for Records

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone #: _____

To **SEND** Records:

I authorize Midwifery and Women's Health Care to **SEND** records to:

Myself

Mail Address: _____

Fax Number: _____

I will pick them up (Call at this phone number when ready: _____)

Provider or Practice: _____

Full Address: : _____

Phone Number : _____ Fax. Number: _____

To **OBTAIN** Records:

I authorize Midwifery and Women's Health Care to **OBTAIN** records from:

Provider or Practice: _____

Full Address: : _____

Phone Number : _____ Fax. Number: _____

<p>Information you are requesting:</p> <p><input type="checkbox"/> Complete medical records</p> <p><input type="checkbox"/> Date range from _____ to _____</p> <p><input type="checkbox"/> Specific records: _____</p> <p>I specifically authorize the release of:</p> <p><input type="checkbox"/> HIV/AIDS related test results <input type="checkbox"/> Drug/alcohol diagnosis and treatment <input type="checkbox"/> Mental health notes</p>

I understand that I may cancel this authorization at any time by giving written notice to Midwifery and Women's Health Care. Unless canceled at an earlier date, this authorization will expire one year from the date of signing below, or on _____.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____